CALIFORNIA CODE OF REGULATIONS

TITLE 22

DIVISION 7

CHAPTER 1
HEALTH PLANNING AND RESOURCES DEVELOPMENT

ARTICLE 5
CERTIFICATE OF NEED

AND

CHAPTER 10
HEALTH FACILITY DATA

ARTICLE 8
PATIENT DATA REPORTING REQUIREMENTS

April 2006

ARTICLE 5: CERTIFICATE OF NEED

90417. Special Fees.

(a) Health Facilities, except those exempt by law and long-term care facilities (as defined by Section 97005(d), California Code of Regulations), shall be charged a special fee as follows:

(1) For the last fiscal year ending on or before June 30, of the preceding calendar year the fee shall be 0.034 percent of the gross operating cost for the provision of health care services as determined by the Office.

(b) Long-term care facilities (as defined by Section 97005(d), California Code of Regulations), except those exempt by law, shall be charged a special fee as follows:

(1) For the last fiscal year ending on or before June 30, of the preceding calendar year the fee shall be 0.034 percent of the gross operating cost for the provision of health care services as determined by the Office.

(c) Freestanding ambulatory surgery clinics as defined in Health and Safety Code 128700(e) shall be charged a special fee that shall be established at an amount equal to the number of ambulatory surgery data records submitted to the Office pursuant to Section 128737 for encounters in the preceding calendar year multiplied by fifty cents ($.50).

Authority: Sections 127150, 128700 and128810, Health and Safety Code
Reference: Sections 127280 and 128737, Health and Safety Code

ARTICLE 8: PATIENT DATA REPORTING REQUIREMENTS

97210. Contact Person, User Account Administrator, Designated Agent, and Facility Identification Number.

(a) Each reporting facility shall designate a primary contact person and shall notify the Office's Patient Data Program in writing, by electronic mail or through the Medical Information Reporting for California (MIRCal) system of the designated person's name, title, telephone number(s), mailing address, and electronic mail address. The designated person will be sent time-sensitive electronic mail regarding the facility's data submission, including reminder notices, acceptance and rejection notifications, and extension information.

(b) Each reporting facility shall notify the Office's Patient Data Program in writing, by electronic mail, or through the MIRCal system within 15 days after any change in the person designated as the primary contact person, or in the designated primary person's name, title, telephone number(s), mailing address or electronic mail address.

(c) Each reporting facility beginning or resuming operations, whether in a newly constructed facility or in an existing facility, shall notify the Office's Patient Data Program in writing, by electronic mail or through the MIRCal system within 30 days after its first day of operation of the designated primary contact person and the facility administrator.

(d) Each reporting facility shall designate up to three User Account Administrators pursuant to Subsection (f) of Section 97246. Each reporting facility shall notify the Office's Patient Data Program in writing, by electronic mail or through the MIRCal system within 15 days after any change in a designated user account administrator's name, title, telephone number(s), mailing address, or electronic mail address.

(e) Each reporting facility may submit its own data report to the Office's Patient Data Program, or it may designate an agent for this purpose. The reporting facility shall be responsible for ensuring compliance with regulations and reporting requirements when an agent is designated pursuant to Subsection (b) of Section 97246.

(1) Each reporting facility shall be provided a facility identification number that shall be used to submit data to the Office.

Authority: Section 128810, Health and Safety Code.
Reference: Sections 128700, 128735, 128736, and 128737, Health and Safety Code.

97227. Definition of Data Element for Inpatients—External Cause of Injury.

The external cause of injury consists of the ICD-9-CM codes E800-E999 (E-codes), that are codes used to describe the external causes of injuries, poisonings, and adverse effects. If the information is available in the medical record, E-codes sufficient to describe the external causes shall be reported for records with a principal and/or other diagnoses classified as injuries or poisonings in Chapter 17 of the ICD-9-CM (800-999), or where a code from Chapters 1-16 of the ICD-9-CM (001-799) indicates that an additional E-code is applicable, except that the reporting of E-codes in the range E870-E879 (misadventures and abnormal reactions) are not required to be reported. An E-code is to be reported on the record for the ~~discharge~~first episode of care reportable to the Office during which the injury, poisoning, and/or adverse effect was ~~first~~ diagnosed and/or treated. If the E-code has been previously reported on a discharge or encounter record to the Office, the E-code should not be reported again on the discharge record. To assure uniform reporting of E-codes, when multiple codes are required to completely classify the cause, the first (principal) E-code shall describe the mechanism that resulted in the most severe injury, poisoning, or adverse effect. If the principal E-code does not include a description of the place of occurrence of the most severe injury or poisoning, an E-code shall be reported to designate the place of occurrence, if available in the medical record. Additional E-codes shall be reported, if necessary to completely describe the mechanisms that contributed to, or the causal events surrounding, any injury, poisoning, or adverse effect.

Authority: Section 128810, Health and Safety Code.
Reference: Section 128735, Health and Safety Code.

97240. Request for Modifications to Patient Data Reporting.

(a) Reporting facilities may file a request with the Office for modifications to Hospital Discharge Abstract Data, Emergency Care Data, or Ambulatory Surgery Data reporting requirements. The modification request must be supported by a detailed justification of the hardship that full reporting of data would have on the reporting facility; an explanation of attempts to meet data reporting requirements; and a description of any other factors that might justify a modification. Modifications may be approved for only one year. Each reporting facility with an approved modification must request a renewal of that approval 60 days prior to termination of the approval period in order to have the modification continue in force.

(b) The criteria to be considered and weighed by the Office in determining whether a modification to data reporting requirements may be granted are as follows:

(1) The modification would not impair the ability of either providers or consumers to make informed healthcare decisions.

(2) The modification would not deprive the public of data needed to make comparative choices with respect to scope or type of services or to how services are provided, and with respect to the manner of payment.

(3) The modification would not impair any of the goals of the Act.

(c) Reporting facilities that did not have any discharges or encounters that are required to be reported pursuant to Section 97213(a) for a specific report period must complete and submit a separate No Data to Report form (OSHPD 2005.1) as Revised on 09/26/2005 on or before the required due date of the report either by using the online screen available through the MIRCal system or by printing the online No Data to Report form and mailing or faxing it to the Office for that report period.

(d) Any facility that is not licensed to provide inpatient care, or does not provide Emergency Care encounters, or does not provide outpatient procedures, or is not licensed as a surgical clinic, and from whom such reporting is not therefore expected, is not required to file a No Data to Report form.

Authority: Section 128810, Health and Safety Code.
Reference: Sections 128735, 128736, 128737, and 128760, Health and Safety Code.

97241. Extensions of Time to File Reports.

(a) Extensions are available to reporting facilities that are unable to complete their submission of reports by the due date prescribed in Section 97211.

(1) Requests for extension shall be ~~postmarked or~~ filed on or before the

required due date of the report by using the extension request screen available through the MIRCal system or by using the Patient Data Reporting Extension Request (form DD1805) as revised 06/09/2005. Notices regarding the use of extension days, and new due dates, as well as notices of approval and rejection, will be e-mailed to the primary contact and Administrator e-mail addresses provided by the facility. If a Designated Agent e-mail contact address has been provided by the facility, this contact will also be notified. These notices will also be available to all facility MIRCal users on the MIRCal Submission Status page. ~~and supported by a written justification that must provide sufficient cause for the approval of the extension request. To provide the Office a basis to determine sufficient cause, the written justification shall include a factual statement indicating:~~

~~(A) the actions taken by the reporting facility to produce the report by the required deadline;~~

~~(B) those factors that prevent completion of the report by the deadline; and~~

~~(C) those actions and the time (days) needed to accommodate those factors.~~

(2) The Office shall respond within 5 days of receipt of the request by either granting what is determined to be a reasonable extension or disapproving the request. ~~If disapproved, the Office shall set forth the basis for a denial in a notice to the reporting facility sent by certified mail. The Office may seek additional information from the requesting reporting facility.~~ The Office shall not grant extensions that exceed the maximum number of days available for the report period for all extensions. If a reporting facility submits the report prior to the due date of an extension, those days not used will be applied to the number of remaining extension days. A reporting facility that wishes to contest any decision of the Office shall have the right to appeal, pursuant to Section 97052.

(b) A maximum of 14 extension days will be allowed for all extensions and resubmittals of reports with discharges or encounters occurring on or after January 1, 2005.

(c) If a report is rejected on, or within 7 days before, or at any time after, any due date established by Subsections (c), or (d), of Section 97211, the Office shall grant, if available, an extension of 7 days. If less than 7 days are available all available extension days will be granted.

(d) If the Office determines that the MIRCal system was unavailable for data submission for one or more periods of 4 or more continuous supported hours during the 4 State working days before a due date established pursuant to Section 97211, the Office shall extend the due date by 7 days.

Authority: Section 128810, Health and Safety Code.
~~Reference: Sections 128735, 128736, and 128737, Health and Safety Code.~~
Reference: Section 128770, Health and Safety Code.

97244. Method of Submission.

(a) Reporting facilities shall use the MIRCal system for submitting reports. Data shall be reported utilizing a Microsoft Internet Explorer web browser that supports a secure Internet connection utilizing the Secure Hypertext Transfer Protocol (HTTPS or https) and 128-bit cypher strength Secure Socket Layer (SSL) through either:

(1) Online transmission of data reports as electronic data files, or

(2) Online entry of individual records.

(b) For Hospital Discharge Abstract Data reports: If an approved exemption is on file with the Office, pursuant to Health and Safety Code Section 128755, a hospital may report discharges on or after January 1, 2003 by diskette, compact disk or Hospital Discharge Abstract Data Record Manual Abstract Reporting Form, provided the hospital complies with the Office's Format and File Specifications for MIRCal Online Transmission Patient Discharge Data as revised in April 2004. The version of the Manual Abstract Reporting Form (OSHPD 1370.IP) to be used is as revised on 03/17/2004. Copies of Form 1370.IP shall be made by the hospital to submit its discharge data and each additional copy shall be made on one sheet, front (Page 1 of 2) and back (Page 2 of 2).

(c) For Emergency Care Data reports: If an approved exemption is on file with the Office, pursuant to Health and Safety Code Section 128755, a hospital may report encounters on or after October 1, 2004 by diskette, compact disk or Emergency Care Data Record Manual Abstract Reporting Form (OSHPD 1370.ED), provided the hospital complies with the Office's Format and File Specifications for MIRCal Online Transmission Emergency Department and Ambulatory Surgery, dated ~~April 2004~~January 2006. The version of the Manual Abstract Reporting Form (1370.ED) to be used is dated ~~03/17/2004~~01/01/2006. Copies of Form 1370.ED shall be made by the hospital to submit its encounter data and each additional copy shall be made on three sheets (Page 1 of 3), (Page 2 of 3), and (Page 3 of 3).

(d) For Ambulatory Surgery Data reports: If an approved exemption is on file with the Office, pursuant to Health and Safety Code Section 128755, a hospital or freestanding ambulatory surgery clinic may report encounters on or after October 1, 2004 by diskette, compact disk or Ambulatory Surgery Data Record Manual Abstract Reporting Form (OSHPD 1370.AS), provided the reporting facility complies with the Office's Format and File Specifications for MIRCal Online Transmission Emergency Department and Ambulatory Surgery, dated ~~April 2004~~January 2006. The version of the Manual Abstract Reporting Form (1370.AS) to be used is dated ~~03/17/2004~~01/01/2006. Copies of Form 1370.AS shall be made by the hospital or freestanding ambulatory surgery clinic to submit its encounter data and each additional copy shall be made on three sheets (Page 1 of 3), (Page 2 of 3), and (Page 3 of 3).

Authority: Section 128755, Health and Safety Code.
Reference: Sections 128735, 128736, and 128737, Health and Safety Code.

97246. Data Transmittal Requirements.

(a) Reporting facilities submitting their own data online must use the MIRCal Online Data Transmittal by Facility method to file or submit each report. The following information must be included: the facility name, the unique identification number specified in Section 97210, the beginning and ending dates of the report period, the number of records in the report and the following statement of certification:

I certify under penalty of perjury that I am an official of this facility and am duly authorized to submit these data; and that, to the extent of my knowledge and information, the accompanying records are true and correct, and that the applicable definitions of the data elements as set forth in Article 8 (Patient Data Reporting Requirements) of Chapter 10 (Health Facility Data) of Division 7 of Title 22 of the California Code of Regulations, have been followed by this facility.

(b) Reporting facilities that choose to designate an agent to submit their records must submit a hardcopy Agent Designation Form (OSHPD 1370.3, Revised: ~~03/17/2004~~06/09/2005), hereby incorporated by reference, to the Office's Patient Data Program. Receipt of a subsequent hardcopy Agent Designation Form supercedes the previous designation. Each reporting facility shall notify the Office's Patient Data Program within 15 days after any change in designated agent.

(c) An agent who has been designated by a reporting facility to submit that facility's data online must use the MIRCal Online Data Transmittal by Agent method to file or submit reports. The following information must be included: the facility name, the facility identification number specified in Section 97210, the beginning and ending dates of the report period, and the number of records in the report.

(d) Reporting facilities with an approved exemption to submit records using either Hospital Discharge Abstract Data Record Manual Abstract Reporting Forms (OSHPD 1370.IP, Revised: 03/17/2004), or Emergency Care Data Record Manual Abstract Reporting Forms (OSHPD 1370.ED dated ~~03/17/2004~~01/01/2006), or Ambulatory Surgery Data Record Manual Abstract Reporting Forms (OSHPD 1370.AS dated ~~03/17/2004~~01/01/2006), ~~–~~diskette, or compact disk, must submit a hardcopy Individual Facility Transmittal Form (OSHPD 1370.1, Revised: ~~03/17/2004~~06/09/2005), hereby incorporated by reference. The Individual Facility Transmittal Form shall accompany the report.

(e) Agents who have been designated by a reporting facility to submit a facility's report in accordance with an approved exemption as described in (d) above must submit a hardcopy Designated Agent~~'s~~ Transmittal Form (OSHPD 1370.2, Revised: ~~03/17/2004~~06/09/2005), hereby incorporated by reference. The Designated Agent~~'s~~ Transmittal Form shall accompany the facility's report.

(f) A facility's administrator may designate no more than 3 ~~Facility~~ User Account Administrators. For each ~~Facility~~ User Account Administrator there must be an original signed ~~Facility~~ User Account Administrator Agreement Form (OSHPD 2002.1, Revised: ~~03/17/2004~~01/05/2006), and hereby incorporated by reference), submitted to the Office.

(g) A signed Designated Agent User Agreement Form (OSHPD 2002.2, Revised: ~~03/17/2004~~01/05/2006), hereby incorporated by reference, must be submitted to the Office by an agent who has been designated to submit data online.

(h) Reporting facilities and designated agents may obtain copies of the forms from the OSHPD web site at www.oshpd.ca.gov or by contacting the Office's Patient Data Program at (916) 324-6147.

Authority: Section 128810, Health and Safety Code.
Reference: Sections 128735, 128736, and 128737, Health and Safety Code.

97250. Failure to File a Data Report.

Any health facility which does not file any report completed as required by this article is liable for a civil penalty of one hundred dollars ($100) a day to be assessed and recovered in a civil action brought in the name of the people of the State of California by the Office for each day that the filing of the report is delayed, considering all approved extensions of the due date as provided in Section 97241. Assessed penalties may be appealed pursuant to Section 97052. Within fifteen days after the date the reports are due, the Office shall notify the health facility of reports not yet received, the amount of the liability, and potential future liability for failure to file reports when due. Sixty days after an original report due date as specified in Section 97211(c), the MIRCal system will close for that report period. No report for the period will be accepted after the MIRCal system closure. No additional penalties will accrue for outstanding reports after the MIRCal system closure for a report period.

Authority: Sections 128810, 128755 (c)(3),(d),and (e) Health and Safety Code.
Reference: Sections 128735, 128736, and 128737, Health and Safety Code

97260. Definition of Data Element for ED and AS—Principal External Cause of Injury.

The external cause of injury consists of the ICD-9-CM codes E800-E999 (E-codes), that are codes used to describe external causes of injuries, poisonings, and adverse effects. If the information is available in the medical record, E-codes sufficient to describe the external causes shall be reported on records with a principal and/or other diagnoses classified as injuries or poisonings in Chapter 17 of the ICD-9-CM (800-999), or where a code from Chapters 1-16 of the ICD-9-CM (001-799) indicates that an E-code is applicable, except that the reporting of E-codes in the range E870-E879 (misadventures and abnormal reactions) are not required to be reported. An E-code is to be reported on the record ~~for the encounter~~ for the first episode of care reportable to the Office during which the injury, poisoning, and/or adverse effect was ~~first~~ diagnosed

and/or treated. If the E-code has been previously reported on a discharge or encounter record to the Office, the E-code should not be reported again on the encounter record. To assure uniform reporting of E-codes, when multiple codes are required to completely classify the cause, the first (principal) E-code shall describe the mechanism that resulted in the most severe injury, poisoning, or adverse effect.

Authority: Section 128810, Health and Safety Code.
Reference: Sections 128736 and 128737, Health and Safety Code.

97261. Definition of Data Element for ED and AS—Other External Cause of Injury.

The external cause of injury consists of the ICD-9-CM codes E800-E999 (E-codes), that are codes used to describe the external causes of injuries, poisonings, and adverse effects. If the information is available in the medical record, E-codes sufficient to describe the external causes shall be reported for records with a principal and/or other diagnoses classified as injuries or poisonings in Chapter 17 of the ICD-9-CM (800-999), or where a code from Chapters 1-16 of the ICD-9-CM (001-799) indicates that an additional E-code is applicable, except that the reporting of E-codes in the range E870-E879 (misadventures and abnormal reactions) are not required to be reported. An E-code is to be reported on the record ~~for the encounter~~ for the first episode of care reportable to the Office during which the injury, poisoning, and/or adverse effect was ~~first~~ diagnosed and/or treated. If the E-code has been previously reported on a discharge or encounter record to the Office, the E-code should not be reported again on the encounter record. If the principal E-code does not include a description of the place of occurrence of the most severe injury or poisoning, an E-code shall be reported to designate the place of occurrence, if available in the medical record. Additional E-codes shall be reported, if necessary to completely describe the mechanisms that contributed to, or the causal events surrounding, any injury, poisoning, or adverse effect.

Authority: Section 128810, Health and Safety Code.
Reference: Sections 128736 and 128737, Health and Safety Code.

97264. Definition of Data Element for ED and AS—Disposition of Patient.

The patient's disposition, defined as the consequent arrangement or event ending a patient's encounter in the reporting facility, shall be reported as one of the following:

(a) Discharged to home or self care (routine discharge).

(b) Discharged/Transferred to a short-term general hospital for inpatient care.

(c) Discharged/Transferred to a skilled nursing facility (SNF) with Medicare certification in anticipation of covered skilled care.

(d) Discharged/Transferred to an intermediate care facility (ICF).

(e) Discharged/Transferred to ~~a non-Medicare PPS children's hospital or non-Medicare PPS cancer hospital for inpatient care~~another type of institution not defined elsewhere in this code list.

(f) Discharged/Transferred to home under care of an organized home health service organization in anticipation of covered skilled care.

(g) Left against medical advice or discontinued care.

(h) ~~Discharged/Transferred to home under care of a Home Intravenous (IV) provider.~~

~~(i)~~ Expired.

(ij) Discharged/Transferred to a Federal health care facility.

(j~~k~~) Discharged home with hospice care.

(k~~l~~) Discharged to a medical facility with hospice care.

(l~~m~~) Discharged/Transferred to a hospital-based Medicare approved swing bed.

(m~~n~~) Discharged/Transferred to an inpatient rehabilitation facility (IRF) including a rehabilitation distinct part unit of a hospital.

(n~~o~~) Discharged/Transferred to a Medicare certified long term care hospital (LTCH).

(o~~p~~) Discharged/Transferred to nursing facility certified under Medicaid (Medi-Cal), but not certified under Medicare.

(p~~q~~) Discharged/Transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital.

(q~~r~~) ~~Other~~ Discharged/Transferred to a Critical Access Hospital (CAH).

(r) Other

Authority: Section 128810, Health and Safety Code.
Reference: Sections 128736 and 128737, Health and Safety Code.

97266. Freestanding Ambulatory Surgery Encounter Fee Assessment

(a) The Office shall mail an annual notice of special fee assessment and a remittance advice form to each freestanding ambulatory surgery clinic. The annual notice of special fee assessment and remittance advice form shall be mailed at least 20 days before the fee due date. The remittance advice form shall be completed by each

surgical clinic and returned to the Office with full payment of the special fee amount. The fee shall be due on July 1st and delinquent on July 31st of each year. The basis of assessment is the number of ambulatory surgery data records submitted to the Office for encounters in the preceding calendar year.

(b) New surgical clinics which had no encounters in the previous calendar year are not liable for the initial special fee.

(c) New surgical clinics that have been operating for less than 12 months in the previous calendar year are liable for the special fee based on the number of ambulatory surgery data records submitted to the Office for encounters during the period of their licensed operations in the previous calendar year.

(d) Where there was a change in licensee during the prior calendar year, the current licensee shall be assessed a special fee based on the number of ambulatory surgery data records submitted to the Office for encounters that occurred during the time of their licensure.

(e) The Office shall determine the basis of assessment for special fee amounts due from surgical clinics in those circumstances not specifically covered above.

(f) To enforce payment of delinquent special fees, the Office shall notify the State Department of Health Services not to issue a license and not to renew the existing license of the delinquent surgical clinic until the special fees have been paid, pursuant to Section 127280, Health and Safety Code. A copy of the Office notice to the State Department of Health Services shall be sent to the delinquent surgical clinic.

Authority cited: Section 127150 and 128810, Health and Safety Code.
Reference: Section 128737 and 127280 Health and Safety Code.